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AIDAC

AFR/SA FOR ELOKEN, LDOBBINS, HIRSCH, HARMON
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TAGS: EAID EAGR PREL PHUM PGOV ZI
SUBJECT: DISASTER DECLARATION IN ZIMBABWE FOR CHOLERA

REF: HARARE 0904

HARARE 00001119 001.2 OF 003

¶1. This is an action cable (see paragraph 15).

SUMMARY

¶2. Beginning in August 2008, cholera outbreaks have spread to affect 9 of the 10 provinces in Zimbabwe. A breakdown in water and sanitation infrastructure has exacerbated Zimbabwe's cholera outbreak, and the nation's collapsed health system is unable to respond adequately. On December 3, the Government of Zimbabwe (GOZ) Minister of Health and Child Welfare declared an emergency and requested international assistance to respond to the cholera outbreak.

¶3. In FY 2008, USAID's Office of U.S. Foreign Disaster Assistance (USAID/OFDA) provided more than USD 4 million to implement water, sanitation, and hygiene (WASH) programs as well as distribute emergency hygiene supplies in anticipation of a cholera outbreak (REFTEL). In early December, USAID/OFDA provided an additional USD 600,000 to Population Services International (PSI) for water treatment supplies and community hygiene education. On December 5, health advisor from USAID/OFDA and a WASH advisor from the U.S. Centers for Disease Control and Prevention (CDC) arrived in Harare to assess the situation. On December 10, to augment ongoing response efforts, USAID/OFDA activated a Disaster Assistance Response Team (USAID/DART). In response to the ongoing cholera outbreaks, the Charge d'Affaires, a.i. declares that a disaster exists, it is beyond the capacity of the GOZ to respond, and that it is in the interest of the U.S. Government (USG) to provide assistance to cholera-affected populations. END SUMMARY.

BACKGROUND

¶4. Beginning in August 2008, cholera outbreaks have spread to affect 9 of the 10 provinces in Zimbabwe. According to relief agencies, the breakdown of Zimbabwe's water, sewage, and sanitation systems due to aging and poorly maintained infrastructure has exacerbated the spread of cholera. USAID/DART staff report that many high-density urban areas lack clean water for months at a time and that residents obtain drinking water from contaminated shallow wells.

¶5. Zimbabwe's health care system remains unable to cope adequately with the outbreak due to collapsing infrastructure, lack of salaries for medical staff, and inadequate soap for medical staff and patients. On December 3, the GOZ Minister of Health and Child Welfare declared an emergency and requested international assistance to respond to the cholera outbreak, including medicine, equipment, and food for patients.

CURRENT SITUATION

¶6. As of December 11, the U.N. World Health Organization (WHO) reported 792 deaths due to cholera, with 16,700 total cases. WHO noted that 60 percent of the cholera cases were reported in Harare and 23 percent in Beitbridge, the southern town which serves as the main entry point to South Africa. WHO reported a case fatality rate (CFR) of approximately 4.7 percent, considerably higher that the 1 percent emergency threshold used by humanitarian organizations. The U.N. Office for the Coordination of Humanitarian Affairs (OCHA) noted that the U.N. health cluster is planning based on a worst case scenario of up to 60,000 cholera cases.

¶7. The USAID/DART public health advisor reported that cholera rates

are declining in current hot spots but are increasing in new locations. OCHA noted that the cholera outbreak caseload in Beitbridge has declined substantially from 300 cases per day to 20 cass per day as of December 10. However, local healt authorities reported nearly 600 cases and 45 chlera deaths in a new outbreak in Chegutu town, suthwest of Harare.

¶8. High-density, peri-urban reas with limited access to clean water remain particularly vulnerable to increased cholera rates. Limited information flow from rural clinics impedes the GOZ Ministry of Health and Child Welfare (MOHCW) and humanitarian organizations from gauging trends in rural areas. In addition, people who do not seek care outside the home may not be included in official statistics. Hyperinflation and a shortage of basic goods have resulted in a lack of access to sugar and salt, both of which could be used to assist with community-based oral rehydration to treat and mitigate the effects of cholera.

¶9. USAID/DART staff report that Harare's hospitals have closed and that additional urban hospitals lack sufficient resources, resulting in residents traveling to rural health facilities and potentially transmitting cholera to new areas. The onset of the November to April rainy season will lead to conditions favorable for increased cholera transmission, while the annual Christmas season migration will likely lead to the spread of cholera to previously unaffected areas of the country.

¶10. In response to the cholera outbreaks, WHO recently deployed a high-level, seven-person team to Zimbabwe to improve coordination of the cholera response. The team includes a logistician, communications officer, social mobilization expert, and a USAID/OFDA-funded epidemiologist. WHO is receiving updated information from the GOZ MOHCW on reported cholera cases and deaths, which is passed to OCHA for inclusion in daily and weekly cholera situation reports.

REGIONAL IMPACT

¶11. According to WHO, the cholera outbreak has affected border areas of neighboring countries, with confirmed cases reported in Botswana, Mozambique, and South Africa, primarily among populations of Zimbabwe nationals. On December 12, the U.S. Embassy in Gaborone reported five confirmed cholera deaths, all among Zimbabwe nationals. As of December 7, the Government of South Africa reported 11 cholera deaths and 751 cases, with a CFR of 1.46 percent. The majority of the cases were reported in Vhembe District of Limpopo Province.

¶12. On December 9, OCHA reported 708 cases and eight deaths in South Africa's Limpopo Province. On December 11, the government of Limpopo Province declared a disaster due to a cholera outbreak in Vhembe District. Within the district, the border town of Musina serves as a primary destination for Zimbabweans seeking medical treatment in South Africa. On December 11, USAID/OFDA's principal regional advisor based in Pretoria, South Africa, traveled to Musina to assess the situation.

USG CHOLERA ASSISTANCE REPONSE TO DATE

¶13. In FY 2008, USAID/OFDA provided the non-governmental organizations Oxfam/UK and World Vision with over USD 4 million to implement water, sanitation, and hygiene (WASH) programs as well as distribute emergency hygiene supplies, including soap, in Bulawayo, Harare, and Masvingo Provinces in anticipation of a cholera outbreak. In early December, USAID/OFDA provided an additional USD 600,000 to PSI for water treatment supplies and community hygiene education.

¶14. On December 5, health advisor from USAID/OFDA and a WASH advisor from CDC arrived in Harare to assess the situation. On December 10, to augment ongoing response efforts, USAID/OFDA activated a Disaster Assistance Response Team (USAID/DART) to monitor and assess humanitarian conditions, identify priority programming needs, and facilitate humanitarian coordination and information sharing.

DISASTER DECLARATION

¶15. ACTION REQUEST: The Charge d'Affaires, a.i. declares that a disaster exists, it is beyond the capacity of the GOZ to respond, and that it is in the interest of the USG to provide assistance to cholera-affected populations. Post requests the release of USD 50,000 under the Ambassador's Authority to purchase relief supplies to meet immediate health and sanitation needs. The funding will be part of the overall USD 6.2 million pledged by USAID to respond to cholera in Zimbabwe. The USAID/DART, in coordination with USAID/Zimbabwe, the U.S. Embassy in Harare, humanitarian partners, and other donors, will continue to closely monitor the situation and conduct assessments to determine any additional humanitarian needs.

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